

Please complete the following information for individuals who have or may have Lyme disease.
FAX completed form to: 613-966-1813 (Confidential) or EMAIL to CDCFax1@hpeph.ca

To request this document in an alternate format, call 613-966-5500; TTY 711, or visit hpePublicHealth.ca

FOR PUBLIC HEALTH USE ONLY:	
iPHIS CASE ID	iPHIS CLIENT ID

HEALTH CARE PROVIDER INFORMATION

Name:		Date (y/m/d):
Facility/Office Name:	Phone #:	Fax #:

PATIENT INFORMATION

Last Name:	First Name:	Gender:
DOB (y/m/d):	Phone #:	Cell #:
Address:	City:	Postal Code:
Health #:	Name of Parent/Guardian (if minor):	

PRIMARY CARE PROVIDER (if diff than above):

RISK FACTORS (Check all that apply)

History of tick bite: YES NO Date (y/m/d):

If YES, where was the patient most likely exposed (approx. geographical location):

Was the patient given prophylactic medication after tick bite: YES NO Date (y/m/d):

If NO history of tick bite, has patient had possible exposure to ticks in the last 30 days during outdoor activities in wooded areas, either through work or recreation: YES NO Date (y/m/d):

If YES, approx. geographical location:

CASE DETAILS

Onset Date of symptoms (y/m/d):	Date of Diagnosis (y/m/d):
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Diagnosis of early localized disease (less than 30 days from exposure): YES NO Check all that apply:

<input type="checkbox"/> Erythema migrans (EM) ≥ to 5 cm in diameter	<input type="checkbox"/> Headache	<input type="checkbox"/> Fever	<input type="checkbox"/> Malaise
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Arthralgia

Diagnosis of early disseminated disease (weeks to months after exposure): YES NO Check all that apply:

<input type="checkbox"/> Multiple EM	<input type="checkbox"/> Cranial Nerve Palsies	<input type="checkbox"/> Lymphocytic Meningitis	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Arthralgia
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Carditis (heart block)	

Diagnosis of late disease (weeks to years after exposure): YES NO Check all that apply:

<input type="checkbox"/> Arrhythmias	<input type="checkbox"/> Myopericarditis	<input type="checkbox"/> Carditis (heart block)	<input type="checkbox"/> Peripheral	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Encephalopathy	<input type="checkbox"/> Recurrent arthritis affecting large joints (i.e. knees)		

LABORATORY TESTING

Testing is not necessary in the early localized disease phase. Diagnostic serological testing is indicated in people who have symptoms of early or late disseminated disease.

Was serological testing done: YES NO	Date (y/m/d):
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Treatment – Has the patient been treated for Lyme Disease: YES NO	Date (y/m/d):
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Medication, dosage, duration:

Have you provided the patient with education on Lyme Disease and tick bite prevention? YES NO
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Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7., s.26; R.R.O. 1990, Reg. 569, s.1 (2), amended and in accordance with PHIPA and will be used for assessment, management, treatment and reporting purposes. Questions about this collection should be addressed to the Privacy Officer at HPEPH, 179 North Park Street, Belleville, ON K8P 4P1 613-966-5500 or 1-800-267-2803.